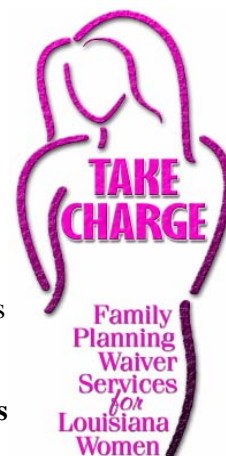


TAKE CHARGE

Family Planning Waiver Application



Use this form to apply for family planning services for Women age 19-44.

How to apply

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof.** Look for a list of things we need beginning on page 6.
3. **Send the application and proofs to us right away. We will give you more time to get the proofs to us if you need it.**

Where to send the application and proofs

Mail to: P.O. Box 91278, Baton Rouge, LA 70821-9278

Fax to: 1-877-523-2987 (toll-free)

Drop off at: Your local Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

What language do you speak best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify) _____

What language do you write best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify) _____

1. Tell Us About You – The woman wanting family planning waiver services.

Name _____
First Middle Initial Maiden Last

Mailing Address _____
Street Address Apartment/Lot Number

City State Zip Code

Home Address (if different) _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Social Security Number _____ - _____ - _____ Date of Birth _____
Month Day Year

Parish Where You Live _____ E-mail Address _____

Home Phone (____) _____ Cell Phone (____) _____ Daytime Phone (____) _____

Best Day/Time to Call Monday through Friday between 8 a.m. and 4:30 p.m. _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Race and Ethnic Background (You do not have to answer. You may mark more than one box.) ☐ White ☐ Black ☐ Asian
☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander

If you have questions or need help with this application, call Medicaid at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. THESE CALLS ARE FREE.

2. Pregnancy

A. Are you pregnant? ☐ Yes ☐ No

B. Were you pregnant in any of the last three months? ☐ Yes ☐ No

3. Citizenship/Immigration Status

A. Are you a U.S. citizen? ☐ Yes – Go to B ☐ No – Answer next questions

Are you a lawful permanent resident? ☐ Yes ☐ No Date you came to the U.S. _____

Permanent Resident Card Number (green card #): A _____

B. Tell us where you were born.

City _____ State _____ Country _____

Mother's Full Name (first, middle initial, last) _____

Mother's Maiden Name _____

4. Tell Us About the Other People Living With You – List your husband first (if married) and then all children under age 18. If no one lives with you, go to Question 5.

*If there are more than 4 people, use a separate sheet of paper. Social Security numbers **must** be given for spouse, children, and anyone who gets Medicaid.*

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ☐ Husband ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ☐ Child ☐ Step-Child ☐ Grandchild ☐ Other _____

5. Health Insurance

Do you have health insurance? ☐ Yes – Fill Out Below ☐ No – Go to Question 6

Policyholder's Name _____ Coverage Start Date _____

Insurance Company Name and Phone Number _____

Policy Number _____ Group Number _____

It covers: ☐ Hospital ☐ Doctor ☐ Medicine ☐ Dental ☐ Ambulance ☐ Pregnancy ☐ Family Planning

6. Medical Procedures

Have you had any medical procedures which would keep you from getting pregnant like having your tubes tied or a hysterectomy? ☐ Yes ☐ No

If yes, you cannot get family planning waiver services through the TAKE CHARGE program.

7. Income from Working

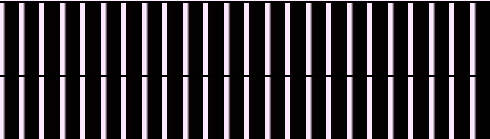
Does anyone work (you, your husband, or children under age 18)? ☐ Yes – Fill out below ☐ No – Go to Question 8

Tell us about **each** full-time job, part-time job, or business.

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (show gross, not take home pay)	How often paid?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

8. Other Income

Tell us about any income that you, your husband, and children under age 18 get, like the kinds listed below.

Income Type		Tell us where this money is from or who pays this money. (name, address, and phone)	Who gets this income?	How much?	How often?
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Money from Friends/Relatives	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Other (tell us what it is) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	

9. Child Support and Alimony Paid to Someone Outside the Home

Do you or does your husband pay **court-ordered** child support or alimony to someone **outside your home**?

☐ Yes ☐ No

If **yes**, to whom? _____ Monthly Amount \$ _____

10. Child Care/Adult Care

Do you or does your husband pay for child care or pay for care for an adult **with a disability** in order to work, go to school, or get training? ☐ Yes ☐ No If **yes**, tell us about it below.

Name of Child(ren) or Adult Who Gets Care _____

Who pays for the care? _____ How much is paid each month? _____

Is help received with paying it from anyone or another program? ☐ Yes ☐ No How much? _____

Name of Center or Caregiver _____ Phone Number (____) _____

11. Where did you get this TAKE CHARGE application form?

☐ Medicaid office ☐ hospital/clinic ☐ pharmacy ☐ doctor's office ☐ school ☐ Internet

☐ Office of Family Support ☐ friend/relative ☐ business ☐ church ☐ festival/health fair

☐ Toll Free hotline number ☐ Social Security Office ☐ other _____

12. Disability Benefits and Medicare

A. Are you unable to work because of a disability? ☐ Yes ☐ No

B. Did you ever get Medicare? ☐ Yes ☐ No

The Medicare Card looks like this.

C. Did you ever receive Social Security Disability payments or SSI? ☐ Yes ☐ No



THIS IS THE END OF THE APPLICATION. YOU MUST SIGN BELOW



By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.



Sign Your Name Here: _____ **Date:** _____

If someone working for Medicaid helped you fill out this form, they will sign below.

_____ **Date:** _____

Please send the application to the TAKE CHARGE program office right away. The address is P.O. Box 91278, Baton Rouge, LA 70821-9278, and the fax number is 1-877-523-2987. We will give you more time to get the proofs to us if you need it.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID/TAKE CHARGE PROGRAM HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid/ **TAKE CHARGE** Program for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid/**TAKE CHARGE** Program get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid/family planning waiver services.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid/family planning waiver services, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid/**TAKE CHARGE** Program has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid/**TAKE CHARGE** Program within 10 days of these changes: 1) if anyone getting family planning waiver services moves out of state; 2) if there are any changes in your mailing or home address; 3) if anyone getting family planning gets health insurance or Medicare; and 4) if anyone getting family planning becomes pregnant.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid/**TAKE CHARGE** Program will only send case information to Child Support Enforcement for medical support if you ask them to.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID/TAKE CHARGE PROGRAM

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand that Medicaid/**TAKE CHARGE** Program cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818

Send Us These Things

Copies of all health insurance cards (front and back.)

If you are **not** a U.S. citizen send copies of Permanent Resident Card (green card) or other proof from U.S. Citizenship and Immigration Services.

If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate or U.S. Passport. If you don't have these, ask us about other things you may use.

Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your husband, and children.

Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return - for you, your husband, and children.

Statement from friends or relatives who give money to you, your husband, or children.

Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.

Court order and proof of alimony or child support that you or your husband **PAYS** to someone **outside your home**. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.

Department of Health and Hospitals
Voter Registration Declaration (Optional)

If you fill it out, your answers will not affect the benefits you get from the
Louisiana Department of Health and Hospitals.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Louisiana Secretary of State
Commissioner of Elections
P.O. Box 94125
Baton Rouge, LA 70804-9125
Phone: (toll-free) 1-800-883-2805

Print Your Name

Social Security Number

Date of Birth

Sign Your Name

Today's Date

ACADIA

Courthouse #115
Crowley, LA 70526-4363
(337) 788-8841
ALLEN
P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966
ASCENSION
828 S. Irma Blvd. #205
Gonzales, LA 70737-3631
(225) 621-5780
ASSUMPTION
P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347

AVOUELLES

312 N. Main St. #E
Marksville, LA 71351-2409
(318) 253-7129

BEAUREGARD

P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955

BIENVILLE

P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407

BOSSIER

P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301

CADDO

P.O. Box 1253
Shreveport, LA 71153-1253
(318)226-6891

CALCASIEU

1000 Ryan St. #7
Lake Charles, LA 70601-5250
(337)437-3572

CALDWELL

P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON

P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493
CATAHOULA
P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745

CLAIBORNE

507 W. Main Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA

4001 Carter St. #4
Vidalia, LA 71373-3021
(318) 3367770

DESOTO

105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149

E. BATON ROUGE

222 St. Louis #201
Baton Rouge, LA 70802-5860
(225) 389-3940

E. CARROLL

P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015

E. FELICIANA

P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105

EVANGELINE

200 Court St. Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538

FRANKLIN

Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 4354489

GRANT

Courthouse
200 Main St.
Colfax, LA 71417-1828
(318) 627-9938

IBERIA

300 S. Iberia St. #110
New Iberia, LA 70560-4543
(337) 369-4407

IBERVILLE

P. O. Box 554
Plaquemine, LA 70765-0554
(225) 687-5201

JACKSON

500 E. Court St. #102
Jonesboro, LA 71251-3400
(318) 259-2486

JEFFERSON

P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191

JEFFERSON DAVIS

302 N. Cutting Ave.
Jennings, LA 7054-65361
(337) 824-0834

LAFAYETTE

1010 Lafayette #313
Lafayette, LA 70501-6885
(337) 291-7140

LAFOURCHE

307 W. 4th St. #101
Thibodaux, LA 70301-3105
(985) 447-3256

LASALLE

P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254

LINCOLN

100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON

P. O. Box 968
Livingston, LA 707540968
(225) 686-3054

MADISON

100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE

129 N. Franklin
Bastrop, LA 71220-3815
(318) 281-1434

NATCHITOCHES

P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS

1300 Perdido #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA

122 St John St #114
Monroe, LA 71201-7342
(318) 3271436

PLAQUEMINES

P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 564-6957

POINTE COUPEE

211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES

701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER

P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND

P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE

400 Capitol St. #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD

8201 W. Judge Perez Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES

P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA

P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES

P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN

1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY

P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN

Courthouse
415 S. Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY

500 Main St. #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY

701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA

P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS

P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE

P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION

P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION

100 N. State St. #120
Abbeville, LA 70510
(337) 898-4324

VERNON

P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690

WASHINGTON

Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER

P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE

P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL

P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA

P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN

Courthouse Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY**Address Change**

Name Change

Party Change

Remarks

Circle One: PA MV RG SDA SS

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Box 4: Provide your age.

Boxes 6 & 14: You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 8, 12 & 13: The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

Box 9: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 18: If you are using this form to request a change of name, you must print the name to be changed here.

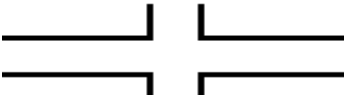
Box 19: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.

LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04				OFFICIAL USE ONLY COMP REG # _____ Reg Type _____ Wd/ Dist _____ Pct _____ In _____ Out _____			
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.							
2 NAME OF APPLICANT (PLEASE PRINT NAME) LAST _____ First _____ FULL MIDDLE OR MAIDEN _____				GIVE LOCATION 			
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY) HOUSE OR APT. NO. & STREET _____ CITY OR TOWN _____ STATE _____ ZIP _____							
IF NO mail delivery to residential address, check here: () _____ MAILING ADDRESS IF DIFFERENT _____							
4 AGE _____	5 DATE OF BIRTH MONTH _____ DAY _____ YEAR _____		6 * SOCIAL SECURITY # (CIRCLE ONE) NO _____ YES # _____	7 SEX (CIRCLE ONE) MALE _____ FEMALE _____	8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE) WHITE _____ BLACK _____ ASIAN _____ HISPANIC _____ AMER. INDIAN _____ OTHER: _____		
9 PARTY AFFILIATION (CIRCLE ONE) DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____			10 APPLICANTS'S PLACE OF BIRTH CITY OR TOWN _____ PARISH OR COUNTY _____ STATE _____ COUNTRY _____			11 MOTHERS MAIDEN NAME _____	
12 ** HOME PHONE () _____		13 ** DAYTIME PHONE () _____		14 LA DRIVERS LICENSE / I.D. # (CIRCLE ONE) NO _____ YES # _____		15 Will you require assistance at the polls? (CIRCLE ONE) NO YES IF YES, GIVE REASON _____	
16 LAST RESIDENCE ADDRESS ADDRESS _____		17 PLACE OF REGISTRATION PARISH OR COUNTY _____ STATE _____		18 FOMER REGISTERED NAME, IF APPLICABLE _____			
AFFIRMATION : I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than \$1,000 (\$2,500 for subsequent offense) or imprisonment for not more than 1 year.							
19 SIGN YOUR NAME IN BOX AT RIGHT DATE: _____ / _____ / _____							
20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE WITNESS SIGNATURE _____ WITNESS SIGNATURE _____							
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only Full # Optional ** OPTIONAL LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04							